

CERTIFICATE OF DEATH

15412

15415

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bitteringer	
c. LENGTH OF STAY IN 1b 23 Days		d. STREET ADDRESS R.F.D. 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oliver Middle Getty Last Beachy		4. DATE OF DEATH Month November Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/76
9. AGE (In years last birthday) yrs. 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (County & State, or foreign country) Bitteringer, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Beachy		14. MOTHER'S MAIDEN NAME Sarah Bowser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-03-7077	
17. INFORMANT Thomas Beachy, Son, Creasaptown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) coronary heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 7 , 1967, to Nov 13 , 1967, that (I) (we) last saw the deceased alive on November 13 , 1967, and that death occurred at 12:38 PM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 11/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Bitteringer Cemetery	23d. LOCATION (City or Town) (County) (State) Bitteringer (Garrett) Md.
24. FUNERAL DIRECTOR Marilou M. Sowers, HAFER-SOWERS Funeral Home, 60 W. Main, Frostburg		25a. REC'D BY REGISTRAR NOV 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

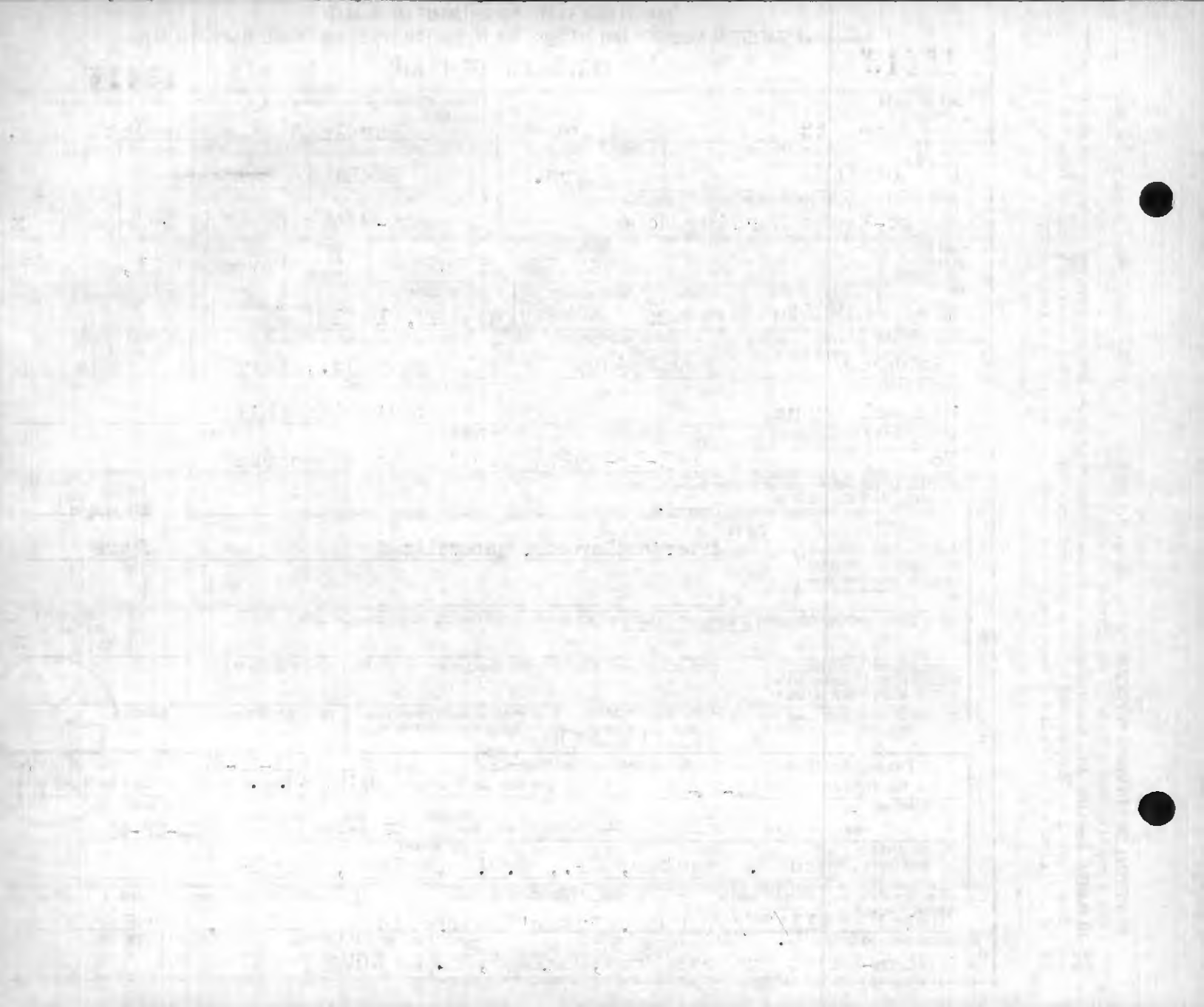
VR A15
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2b,c & d Film #G395 11/30/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett/ Alleg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 5 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland/ Frostburg		01-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cuppert-Weeks Nursing Home		d. STREET ADDRESS Gunter Hotel Cuppert-Weeks Nursing Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle FRANCIS Last BYRNE		4. DATE OF DEATH Month November Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1882
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 10 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd jobs	
11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Byrne		14. MOTHER'S MAIDEN NAME Christine Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 63-16-0927	
17. INFORMANT Nursing home records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerosis, generalized DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 11-21-67 , 19 11-21-67 , that (I) (we) last saw the deceased alive on 11-21-67 , 19 11-21-67 , and that death occurred at 4:45 PM from causes and on the date stated above.			
22a. SIGNATURE James H. Feaster, Jr., M.D.		22b. DATE SIGNED 11-22-67	
22c. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M.D.		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/67	
23c. NAME OF CEMETERY OR CREMATORY St. Peter's Catholic		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR John O. Durst		25a. REC'D BY REGISTRAR NOV 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15414

15417

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY West Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 2 days-17 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS Rt. 1 Box 104A		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosala Middle Maude Last Cummings				4. DATE OF DEATH Month November Day 4 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1907	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 67	IF UNDER 24 HRS. Months 4 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Aurora (Preston) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Arnold Knotts				14. MOTHER'S MAIDEN NAME Virginia Ann Fink			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 32-60-5250		17. INFORMANT A. D. Cummings Address See no. 2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO (b) Myocardial Infarction DUE TO (c) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 4 days 3 mos unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 , to Nov , 19 67 , that (I) (we) last saw the deceased alive on Nov. 3 , 19 67 , and that death occurred at 3:45 PM from causes and on the date stated above							
22a. SIGNATURE B. L. Grant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 NOV. 67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant				22d. ADDRESS Oakland, Maryland 21550			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/67		23c. NAME OF CEMETERY OR CREMATORY Stemple Ridge Cem.		23d. LOCATION (City or Town) (County) (State) Preston Co., W. Va.	
24. FUNERAL DIRECTOR Gerald D. Minnich ADDRESS Oakland, Maryland				25a. REC'D BY REGISTRAR DATE NOV 7 1967		25b. REGISTRAR'S SIGNATURE J. L. Judge	

MEDICAL CERTIFICATION

1153

1153

May 11, 1954

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

1153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17023

15415

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville	
c. LENGTH OF STAY IN 1b 5 days-14 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 11-1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pearl Ada Friend		4. DATE OF DEATH Month November Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 4, 1891
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Friendsville, Maryland	
11. BIRTHPLACE (County & State, or foreign country) Garrett Co. Friendsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Riley		14. MOTHER'S MAIDEN NAME Alice Van Sickle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. mae frazer	
17. INFORMANT Markleysburg, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System DUE TO Diabetes Mellitus DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 6 days years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 65 , to Apr 30 , 19 67 that (I) (we) last saw the deceased alive on Nov. 29 , 19 67 , and that death occurred at 2:30 AM from causes and on the date stated above			
22a. SIGNATURE A E Mance		22b. DATE SIGNED 30 Nov 67	
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance		22d. ADDRESS Oakland, Maryland 21550	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/2/67	23c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery	23d. LOCATION (City or Town) (County) (State) Friendsville, Md.
24. FUNERAL DIRECTOR Magdon F. Williams		25a. RECD BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

1897

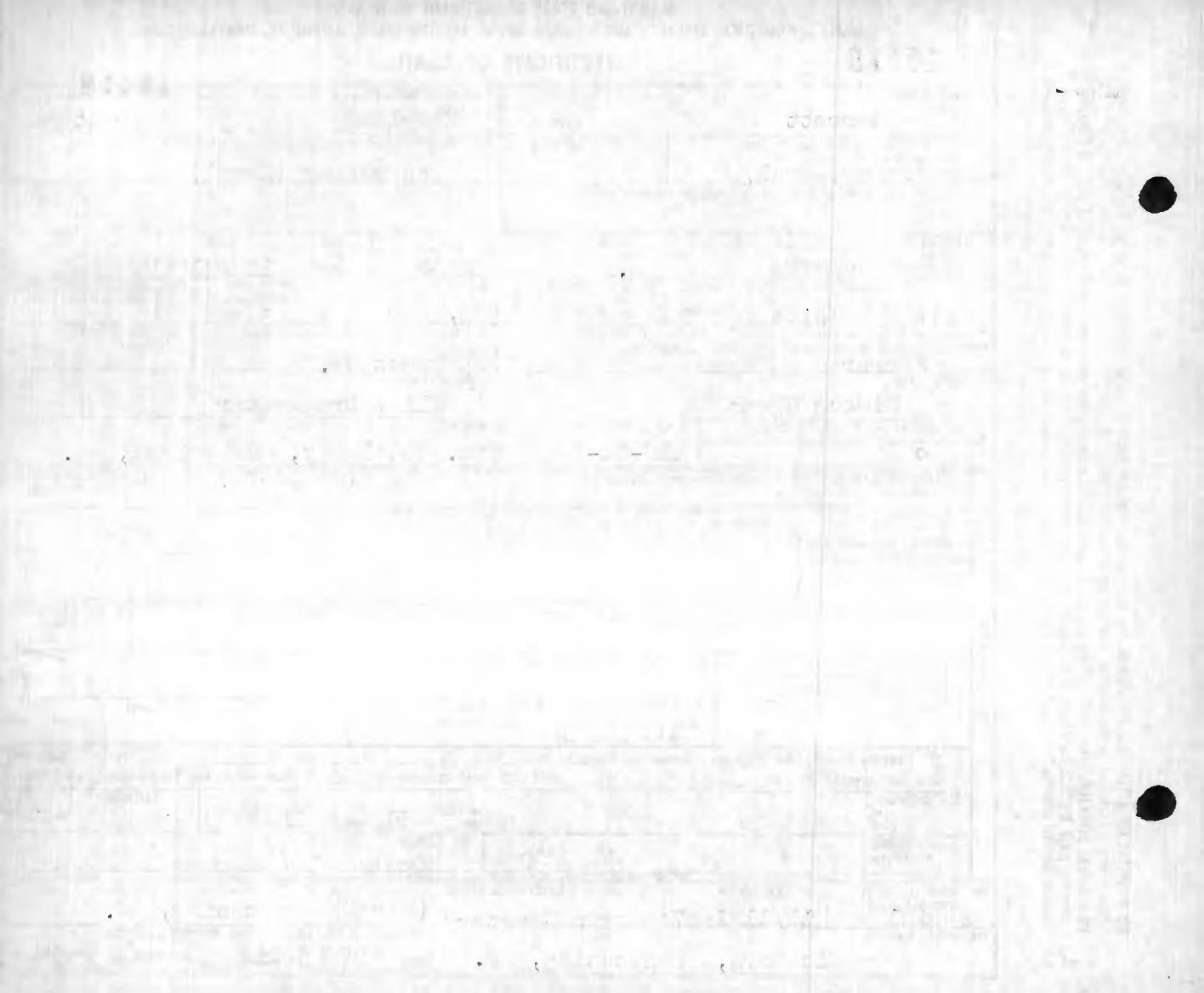
15418

CERTIFICATE OF DEATH

15418

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

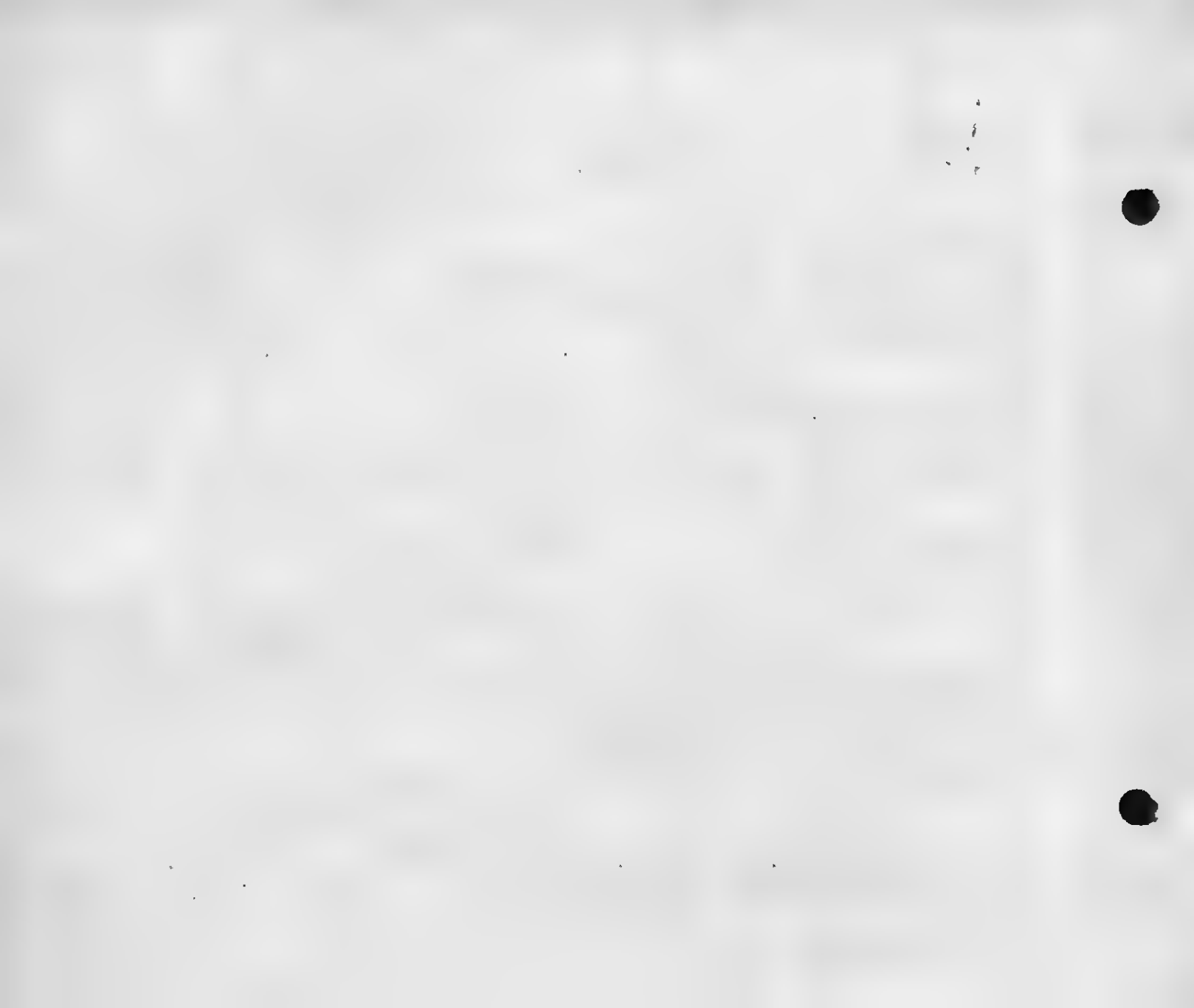
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First CHESTER Middle A. Last GREEN		4. DATE OF DEATH Month 11 Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		9b. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Garrett Co.	
11. BIRTHPLACE (County & State, or foreign country) Garrett Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simeon Green		14. MOTHER'S MAIDEN NAME Eliza Broadwater	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-5922	
17. INFORMANT Mrs. Ethel May, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) Coronary Occlusion DUE TO (c) Dead on arrival		INTERVAL BETWEEN ONSET AND DEATH 30 Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 8 , 19 67 , to Nov. 8 , 19 67 , that (I) (we) last saw the deceased alive on Oct. 25 19 67 , and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED Nov. 10, 1967	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.		22d. ADDRESS 111 Ashfield St. Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/11/1967	23c. NAME OF CEMETERY OR CREMATORY Green Cemetery (Rural)	23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE NOV 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
15417															
15-19															
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>4 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1206 Broadford Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> d. STREET ADDRESS <u>1206 Broadford Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Edward Elmer Householder</u>				4. DATE OF DEATH <u>Nov. 16, 1967</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 30, 1900</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lock Master</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Corps of Eng.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Elizabeth, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Householder</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Actor</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>1208-16-2903</u>			
17. INFORMANT <u>Mrs. Evelyn Householder see #2 above</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>6 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 30, 1964</u> to <u>Nov. 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1, 1967</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Herbert H. Leighton</u>				22b. DATE SIGNED <u>17 Nov 67</u>				22c. PHYSICIAN'S NAME (Type) <u>HERBERT H. LEIGHTON, M.D.</u>				22d. ADDRESS <u>OAK AT FIFTH Oakland, Md. 21550</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/19/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Oakland Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gerard D. Minnick</u>				ADDRESS <u>Oakland, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15418

15420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE West Virginia b. COUNTY Tucker	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davis	
c. LENGTH OF STAY IN 1b 38 days-18 hrs.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rose Victoria Jones		4. DATE OF DEATH Month Day Year November 2, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Barnum, West Virginia		12. (1) ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James William Nogle		14. MOTHER'S MAIDEN NAME Prudence Jane Rohe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Herbert Jones		Address Davis, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Septicemia T.U. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) pyelitis - RT (c) Granulomatous Arterio Sclerotic		INTERVAL BETWEEN ONSET AND DEATH 3 days months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1958 to 2 Nov 1967 , that (I) (we) lost saw the deceased alive on 1 Nov 1967 , and that death occurred at 4:45 M, from causes and on the date stated above			
22a. SIGNATURE A. E. Mance		22b. DATE SIGNED 2 Nov 67	
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance		22d. ADDRESS Oakland, Maryland 21550	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/5/1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or town) (County) (State) Thomas, Tucker W/Va.
24. FUNERAL DIRECTOR John L. Finkle		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 6 1967	



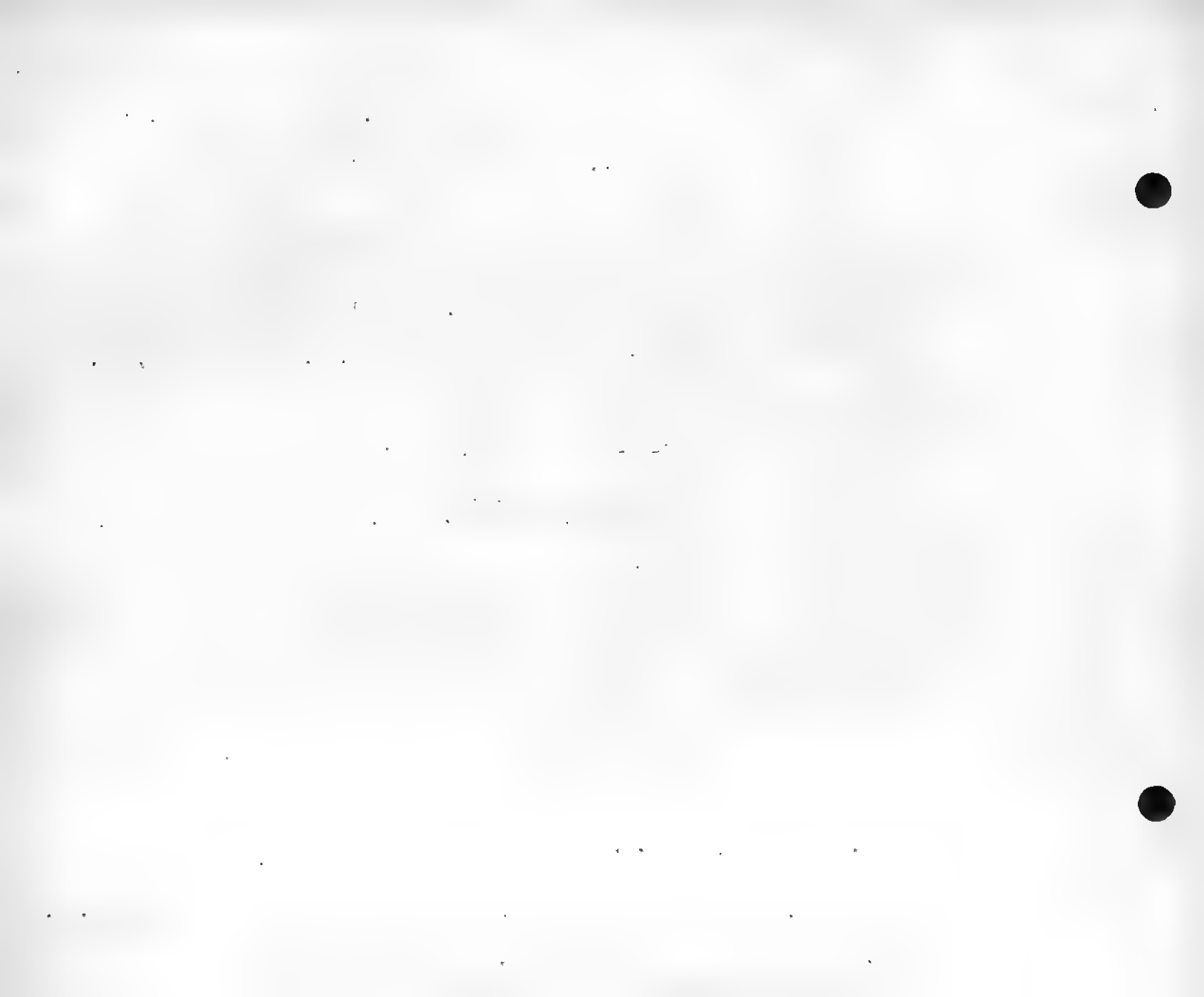
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bloomington</u> c. LENGTH OF STAY IN 1b <u>1 Yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bloomington</u> d. STREET ADDRESS <u>111</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mina</u> Middle <u>I</u> Last <u>Lipscomb</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1918</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Preston-W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Page Durr</u>		14. MOTHER'S MAIDEN NAME <u>Dora Sanders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>233-72-2682</u>	
17. INFORMANT <u>Olaude Lipscomb-Bloomington, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO <u>Hypertensive cardio-vascular-renal disease</u> (b) <u>Diabetes Mellitus</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>67</u> , to <u>Nov 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>28 Nov</u> , 19 <u>67</u> , and that death occurred at <u>4</u> p.m., from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Reeves</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Norman Reeves</u> M.D.		22d. ADDRESS <u>Westernport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Potoac Valley Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Keyser W. Va.</u>	
24. FUNERAL DIRECTOR <u>E. J. Boral</u> ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 4 1967</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-200. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Ohio b COUNTY Meigs	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c LENGTH OF STAY IN 1b Minutes	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Mem. Hosp.		d STREET ADDRESS Rt. 2	
3 NAME OF DECEASED (Type or print) First Freeland Middle Eugene Last Norris		4 DATE OF DEATH Month November Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/21/31
9 AGE (In years last birthday) 36		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b KIND OF BUSINESS OR INDUSTRY Trucking	
11 BIRTHPLACE (State or foreign country) Meigs Co., Ohio		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Floyd Norris		14 MOTHER'S MAIDEN NAME Pearl Edwards	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 302-26-2736	
17 INFORMANT Earlene Norris		Address See # 2 above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Head Injuries DUE TO (b) 1954 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Minutes INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) One car auto accident Rt. 50 near Mt. Storm, W. Va.			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) One car auto accident Rt. 50 near Mt. Storm, W. Va.	
20c TIME OF INJURY Month, Day Year Hour 10 PM 11-25 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work Highway	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural Mt. Storm Grant W. Va.		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		22. DATE SIGNED Oakland, Md. 11-25-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/29/67	
23c NAME OF CEMETERY OR CREMATORY Letart Cemetery		23d LOCATION (City or Town) (County) (State) Racine Rt. 2 Ohio	
24. FUNERAL DIRECTOR Gerald M. Minnich		25a REC'D BY REGISTRAR Charles J. J...	
ADDRESS Oakland, Maryland		25b REGISTRAR'S SIGNATURE DEC 8 1967	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

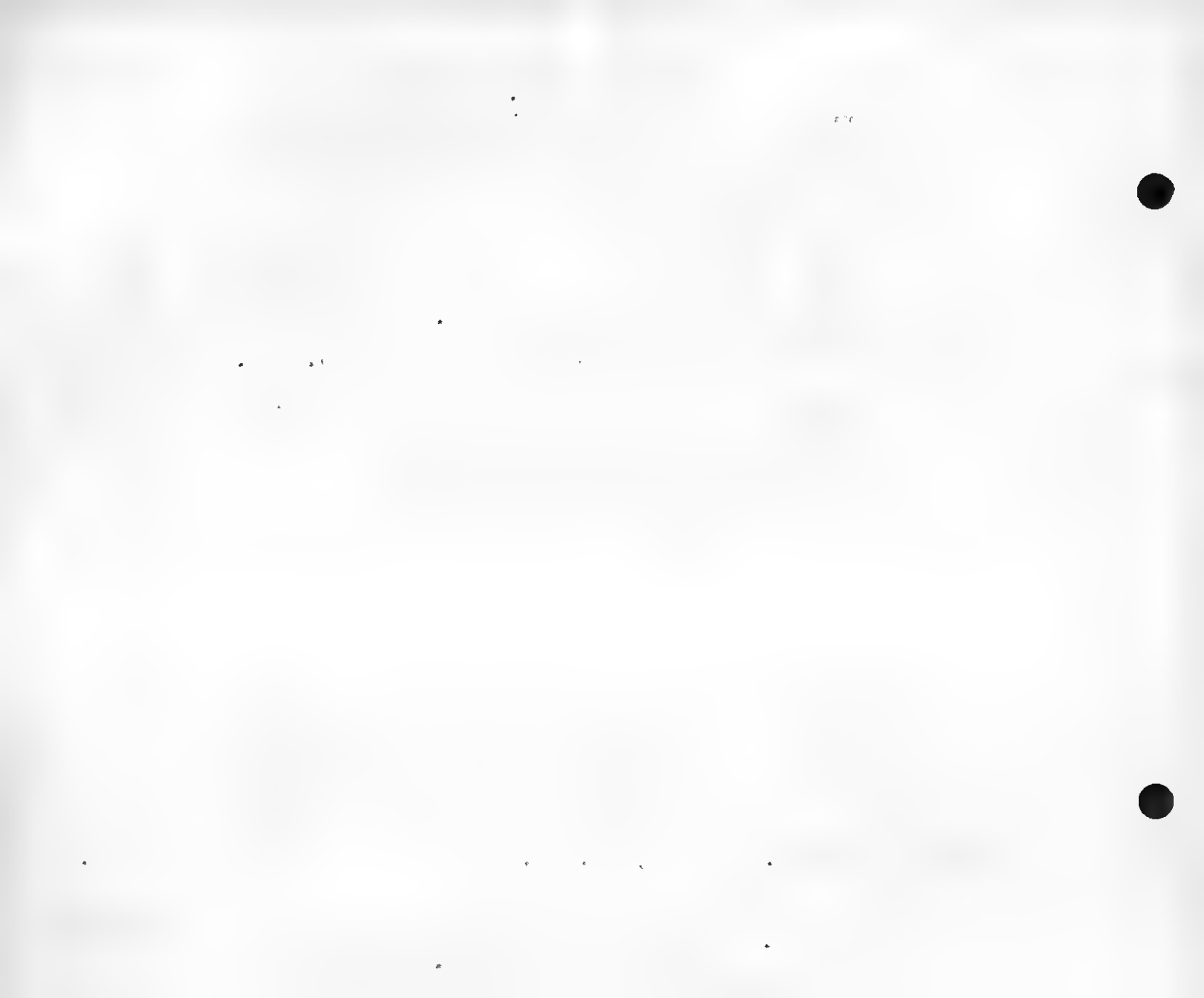
11-22

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland		c. LENGTH OF STAY IN It 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosedale Section		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMANDA Middle CATHERINE Last REXRODE		4. DATE OF DEATH Month November Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 20, 1891
9. AGE (in years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 11 Days 10 Hours 00 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Rexrode		14. MOTHER'S MAIDEN NAME Anna Sweitzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) No		16. SOCIAL SECURITY NO. Woodrow Rexrode, Deer Park, Maryland	
17. INFORMANT (Son)		18. ADDRESS Woodrow Rexrode, Deer Park, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis			
DUE TO (b) Arteriosclerosis, generalized			
DUE TO (c) Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Peaster, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Peaster, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) Oakland, Md.		DATE SIGNED 11-30-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/3/67	23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	23d. LOCATION (City or town) (County) (State) Deer Park, Maryland
24. FUNERAL DIRECTOR John O. Durst		25a. REC'D BY REGISTRAR DEC 4 1967	
Leighton-Durst Funeral Home, Oakland, Md.		25b. REGISTERED SIGNATURE James H. Peaster, Jr.	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

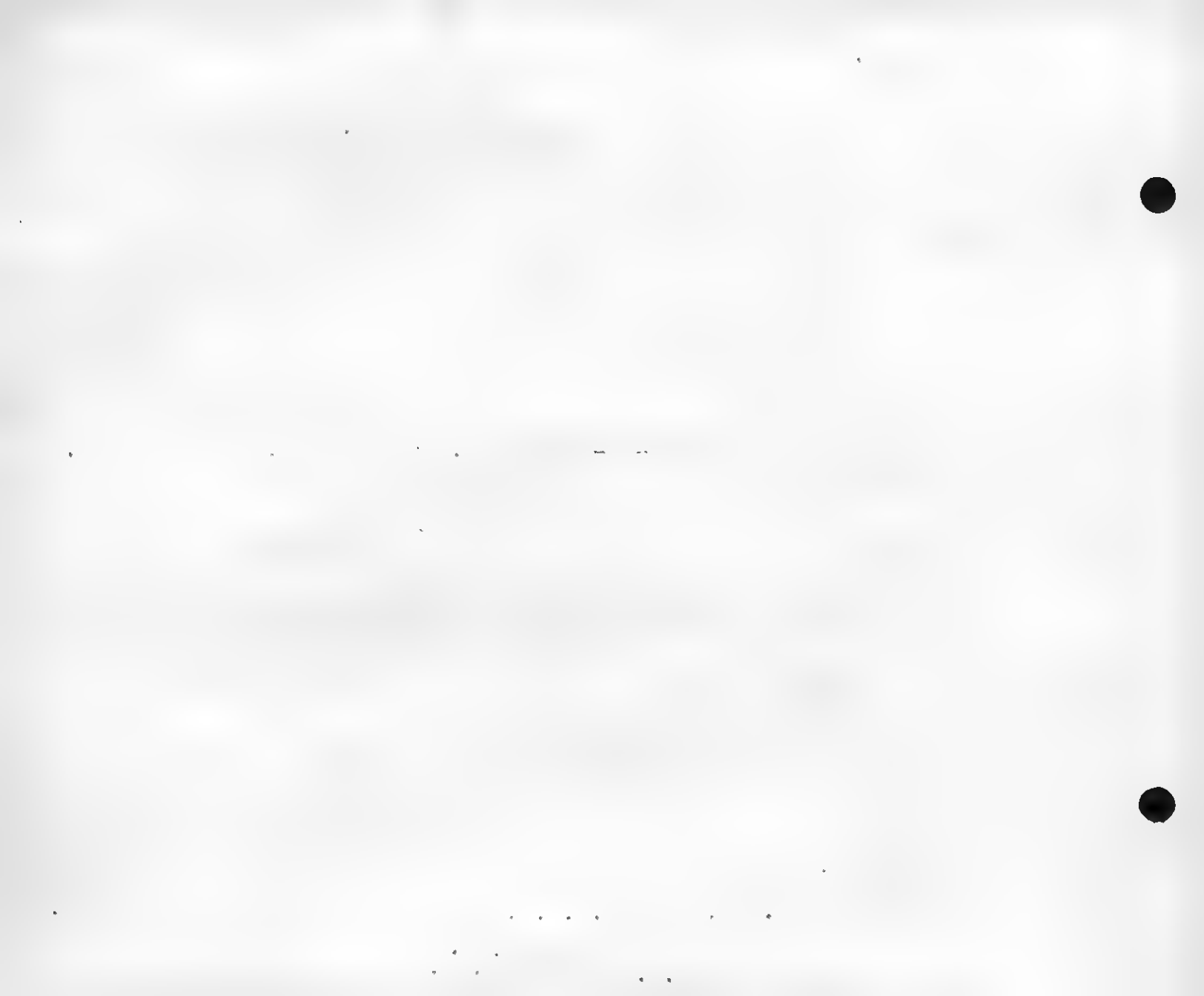
15522

CERTIFICATE OF DEATH

1012.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE W. Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 19 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. STREET ADDRESS Elk Garden	
3 NAME OF DECEASED (Type or print) First Middle Last Samuel Wheeler Rhodes		4 DATE OF DEATH Month Day Year November 16, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-7-80
9a USUAL OCCUPATION (Give kind of work done during last 12 months, if any) Retired Miner		9b KIND OF BUSINESS OR INDUSTRY Coal Mines	9c AGE (in years last birthday) 87 yrs
10a USUAL OCCUPATION (Give kind of work done during last 12 months, if any) Retired Miner		10b KIND OF BUSINESS OR INDUSTRY Coal Mines	10c BIRTHPLACE (County & State, or foreign country) Maryland
11 CITIZEN OF WHAT COUNTRY? America		12 CITIZEN OF WHAT COUNTRY? America	
13 FATHER'S NAME Theodore Rhodes		14 MOTHER'S MAIDEN NAME Mary Elizabeth Farety	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 215-10-5609	
17 INFORMANT A. Mrs. Mary Crouse, Shalimar, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO (b) Cerebral artery disease DUE TO (c) Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 20, 1967 , to 11-16 1967 , that (I) (we) last saw the deceased alive on November 15, 1967 , and that death occurred at 12:20 M. from causes and on the date stated above			
22a. SIGNATURE A. E. Mance		22b. DATE SIGNED 16 Nov 67	
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance		22d. ADDRESS Oakland, Maryland	
23a BURIAL, CREMATION, or other disposition Burial	23b DATE THEREOF Nov. 18, 1967	23c NAME OF CEMETERY OR CREMATORY I.O.O.F. cemetery	23d LOCATION (City or Town) (County) (State) Elk Garden, Mineral Co. W. Va.
24 FUNERAL DIRECTOR Amy Miedel Shapless		25a REC'D BY REGISTRAR P. O. Kitzmiller, Md.	
25b REGISTRAR'S SIGNATURE W. L. Miller, Judge		DATE NOV 20 1967	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

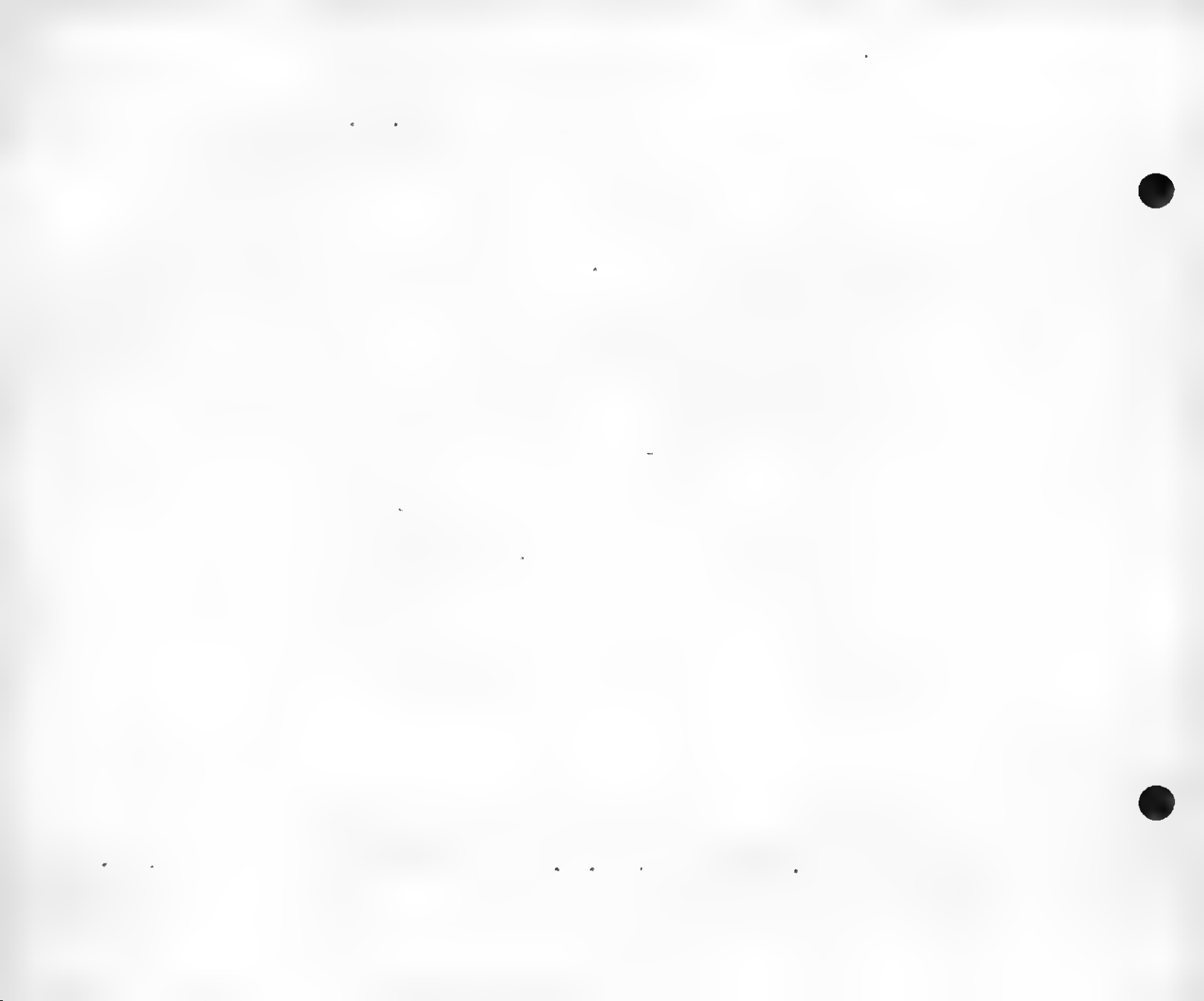
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE W.Va. b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) RURAL Kingwood	
		d. STREET ADDRESS route 1	
3 NAME OF DECEASED (Type or print) John H. Riggs		4 DATE OF DEATH November 13th 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/8/1884
9 AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line Foreman		10b. KIND OF BUSINESS OR INDUSTRY Lining	
11 BIRTHPLACE (State or foreign country) Austin, W.Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Matthew Riggs		14 MOTHER'S MAIDEN NAME Ellen Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 236-12-12224	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis, generalized DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSES WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md. 11-13-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/1967	23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery	23d. LOCATION (City or town) (County) (State) Kingwood Preston W.Va.
24. FUNERAL DIRECTOR <i>Wm. L. Little</i> Terra Alta, West Va.		25. REGD BY REGISTRAR NOV 17 1967	25b. REGISTRAR'S SIGNATURE <i>James H. Feaster, Jr.</i>



15624

CERTIFICATE OF DEATH

1967

1 PLACE OF DEATH a. COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park	
c. LENGTH OF STAY IN 1b 35 yrs.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle LEE Last RODEHEAVER		4. DATE OF DEATH Month November Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1894 73 yrs
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY General Farming	
11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson Rodeheaver		14. MOTHER'S MAIDEN NAME Virginia Friend	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 215-20-6788	
17. INFORMANT (Widow) Mrs. Robert Lee Rodeheaver		Address Deer Pk.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Arrhythmia Fibrillation DUE TO (c) Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1963 to Nov. 25, 1967 , that (I) (we) last saw the deceased alive on Nov 22 1967 , and that death occurred at 1:44 P.M. from causes and on the date stated above			
22a. SIGNATURE Herbert H. Leighton		22b. DATE SIGNED 27 Nov 67	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/67	
23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION (City or Town) (County) (State) Deer Park, Maryland	
24. FUNERAL DIRECTOR Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR DATE NOV 30 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

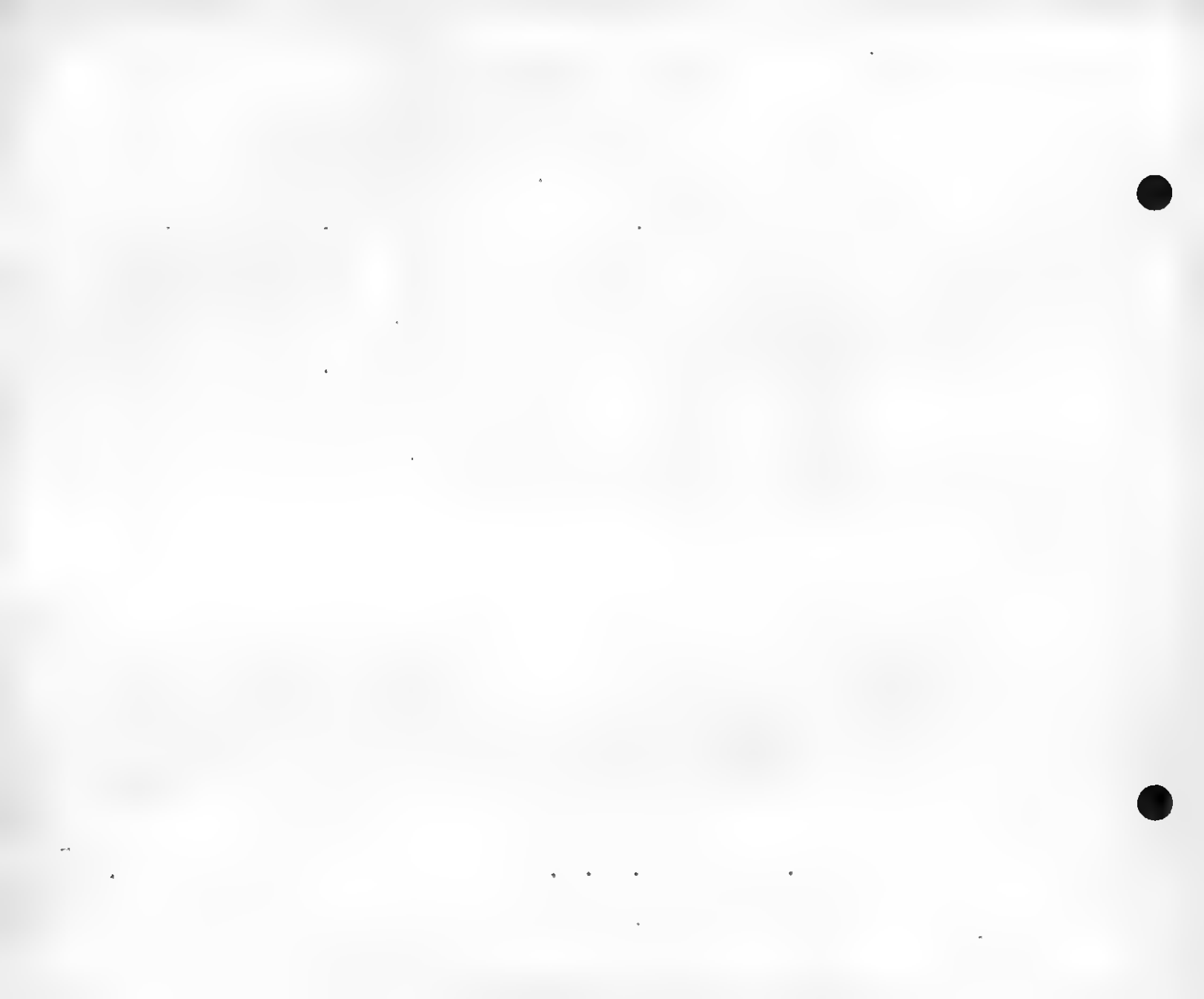
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN It 50 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 143 N. Wilson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Beulah Shreve		4. DATE OF DEATH Month Nov. Day 30. Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1883
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 11 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Garrett Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Beckman		14. MOTHER'S MAIDEN NAME Louisa O'Brien	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220-48-9876	
17. INFORMANT Walter S. Shreve, Jr.		Address Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4201			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		22. DATE SIGNED 11-30-67	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/2/67	23c. NAME OF CEMETERY OR CREMATORY N. Glade Cemetery	23d. LOCATION (City or Town) (County) (State) Garrett Co. Maryland
24. FUNERAL DIRECTOR Gerald N. Minnich		25a. REC'D BY REGISTRAR Oakland, Maryland	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE DEC 8 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

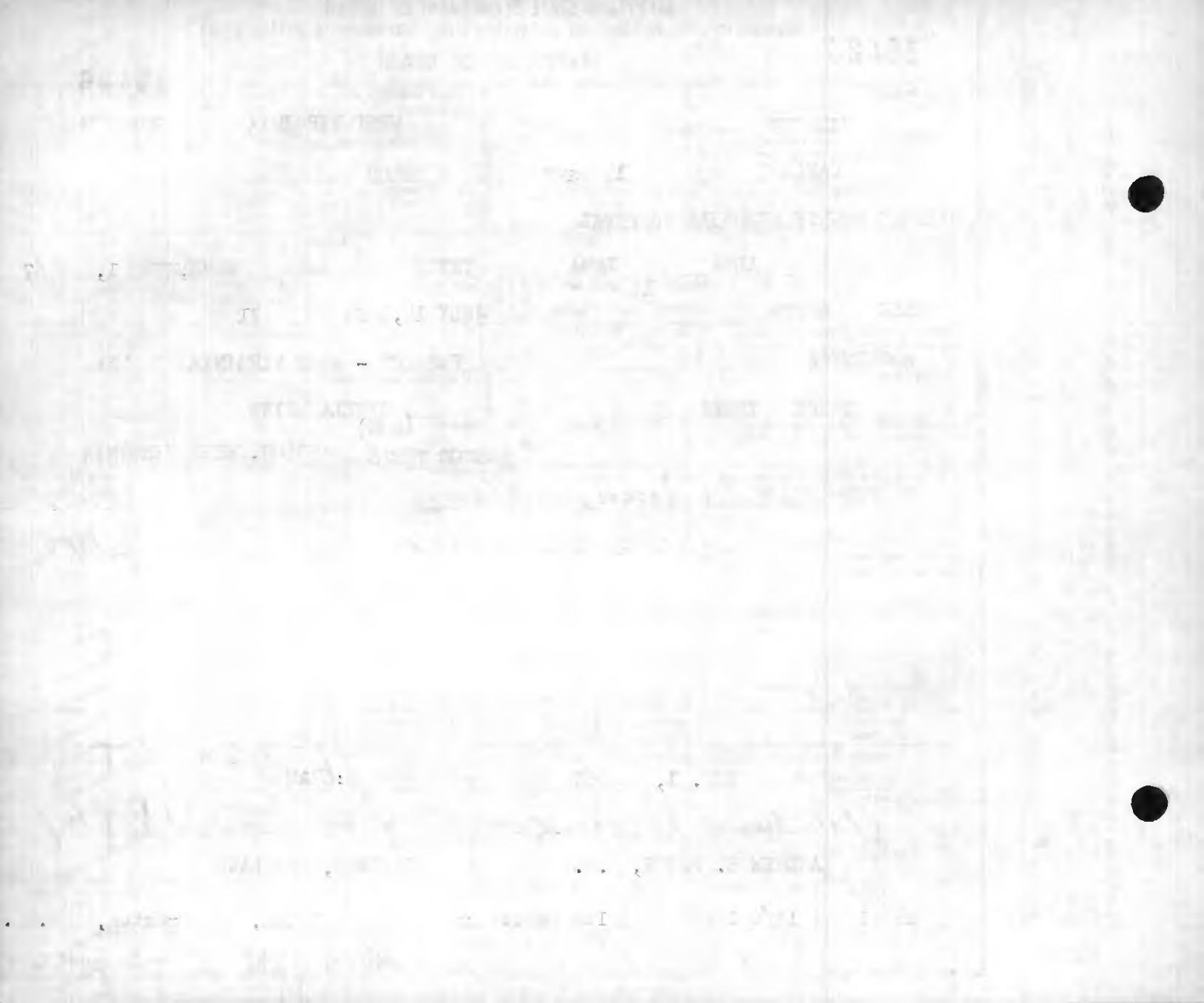
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 17 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EGLON		d. STREET ADDRESS 25-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALTA LENA TEETS		4. DATE OF DEATH Month Day Year NOVEMBER 1, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PRESTON - WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY TEETS		14. MOTHER'S MAIDEN NAME STELLA FIKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (SON) ROSCOE TEETS		Address EGLON, WEST VIRGINIA	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Carcinoma colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 6 mos 8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 1 Nov 1967 , that (I) (we) last saw the deceased alive on NOV. 1, 1967 , and that death occurred at 8:07AM from causes and on the date stated above			
22a. SIGNATURE Andrew E. Mance M.D.		22b. DATE SIGNED 1 Nov 67	
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/4/1967	
23c. NAME OF CEMETERY OR CREMATORY Eglon Cemetery		23d. LOCATION (City or Town) (County) (State) Eglon, Preston, W. Va.	
24. FUNERAL DIRECTOR Robert Finkle		25a. REC'D BY REGISTRAR DAVIS, Wb.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 6 1967	



CERTIFICATE OF DEATH

15427

17041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 316-S. 6th STREET	
3. NAME OF DECEASED (Type or print) ALBERT LEWIS		4. DATE OF DEATH NOVEMBER 29, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1889
9. AGE (In years lost birthday) 78/11 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACKMAN	
11. BIRTHPLACE (County & State, or foreign country) GARRETT - MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS (NONE)		14. MOTHER'S MAIDEN NAME ELLEN JAMISON LITTLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 705-09-4867	
17. INFORMANT (SELF) ALBERT L. WALTER -		Address OAKLAND, MD. 21550	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Congestive Heart Failure DUE TO (b) Arteriosclerotic C V Disease DUE TO (c) 413			INTERVAL BETWEEN ONSET AND DEATH 6 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Unema			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 67 , to 11/29/ , 19 67 , that (I) (we) last saw the deceased alive on 11/29/ , 19 67 , and that death occurred at 8:15 PM , from causes and on the date stated above			
22a. SIGNATURE B. L. Grant		22b. DATE SIGNED 29 NOV 67	
22c. PHYSICIAN'S NAME (Type) B.L. GRANT, M.D.		22d. ADDRESS THIRD STREET - OAKLAND, MD. 21550	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/2/67	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION (City or Town) (County) (State) Oakland Maryland
24. FUNERAL DIRECTOR Gerald D. Minnich		25a. REC'D BY REGISTRAR DEC 8 1967	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

